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ABSTRACT

This document provides research findings, a discussion of etiology, case studies, and treatment approaches for anorexia nervosa. The research findings classify the anorexic patient by sex, age, presenting characteristics, socioeconomic status, premorbid personality, and cultural and familial characteristics. The etiology of anorexia nervosa is presented according to four major theories: biochemical, neuroendocrinological, developmental, and familial. Two anecdotal case studies are presented in detail. Treatment is reviewed according to correlates of success and interventions. Phases of treatment follow from identification of disorder, to body system stabilization, to therapeutic intervention. Various drugs fourd effective in treatment are reviewed as well as therapeutic interventions, including psychotherapy, hypnosis and biofeedback, and behavior modification. A bibliography is included. (BL)

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SYMPTOMS, CAUSES AND POSSIBLE TREATMENT OF ANOREXIA NERVOSA

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ANOREXIA NERVOSA

INTRODUCTION

Anorexia Nervosa is an eating disorder which is characterized by severe and prolonged loss of appetite. "I am just not hungry," "I don't feel like eating, " and, "I don't care for anything," are the common sayings of an anorexic patient. Those who suffer from this disorder exhibit other symptoms such as exhaustion due to lack of nutrition. Other symptoms include scaly skin, lowered pulse rate and low body temperature. In children, the common symptoms which accompany loss of appetite include thumb-sucking, bed-wetting, and various nervous habits.

Physicians have questioned the inclusion of Anorexia Nervosa among the psychophysiological disorders. Some psychiatrists have actually attributed the disorder to inner motivations, such as, "drive toward emaciation." This disorder is a self-imposed restriction of food intake. Some classify it as the expression of a neurotic personality structure. In Anorexia Nervosa, complete denial of the severe emaciation and of the accompanying fatique and other symptoms appears to be characteristic. Anorexics, according to most research are defiant and stubborn, and impress one on first contact as strong and vigorous.

According to Bilz, (1979) Anorexia Nervosa may be a throwback to the vagabond type of feeding. A flight from the feudal organization of the family table, with the patients avoid regular meals, but living

on secret snacks, obtaining their food here and there, sometimes even resorting to stealing. Foucher (1962) explained that;[1]

> "With the haunting specter of starvation hanging over mankind, deliberate refusal of food is a complex, rather, "unnatural" phenomenon. Voluntary abstinence from food is a prescribed ritual in many religious traditions, an effort to liberate oneself from selfish and materialistic concerns, and to purify body and soul. Whether such ascetic denial could lead to enlightenment and salvation was put to the test by Buddha."

According to (Halmi 1974) Anorexia Nervosa is characterized by behavior directed toward losing weight, peculiar patterns of handling food, weight loss, intense fear of gaining weight, disturbance of body image, and in women, amenorrhea. It is one of the few psychiatric illnesses that may have a course unremitting until death.

As early as 1689, Richard Morton diagnosed Anorexia as a, "nervous consumption," described it as;[2]

> "A skeleton only clad with skin, yet there was no fever, but on the contrary a coldness of the whole body; no cough, or difficulty of breathing, nor an appearance of any other distemper of the lungs, or of any other Entrail; no looseness, or any other sign of a colliquation, preternatural expence of the nutritious juices. Only her appetite was diminished, and her digestion uneasy, with fainting fits which did frequently return upon her." Morton (1689).

Many researchers have argued against the term, "Anorexia Nervosa" as a lack or loss of appetite. The young, mostly females, who constitute the great majority of Anorexia Nervosa patients may not, as the name suggests, suffer from a lack of appetite. Rather their condition may stem from a pathological fear of being fat. This overwhelming fear overrides their hunger, which is sometimes voracious. Many of such patients demonstrate periodic breakthroughs of extreme hunger in episodes of uncontrollable eating. After the binges, they induce them-

themselves to vomit. Many of these patients also use laxatives and diuretics to decrease their weight.

At the time Anorexia Nervosa was not a well-known disease, many patients were mis-diagnosed as malabsorption syndrome, a malignancy, a pituitary disorder, or possibly schizophrenia. The ability to diagnose cases sooner and more accurately has been due to the learnable criteria of Feighner (1972) and the DSM III (1980).

Feighner et al (1972), developed the following research criteria for the specific definition of Anorexia Nervosa:[3]

1. Age of disease at onset less than 24 years;
2. Weight loss in excess of 25 percent of the original body weight;
3. The presence of a distorted attitude toward eating or body weight;
4. No known medical illness to account for the weight loss;
5. No other known psychiatric disorder;
6. The presence of at least two of these problems: amenorrhea, lanugo, bradycardia, overactivity, bulimia and vomiting.

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM III), the diagnostic criteria for Anorexia Nervosa are as follows:

1. Refusal to maintain body weight over a minimal normal weight for age and height.
2. Weight loss of at least 25 percent of original body weight or if patient is under 18 years of age, weight loss from original body weight plus projected weight gain expected on pediatric growth charts may be combined to total the 25 percent.
3. Disturbance of body image with inability to perceive body size accurately.
4. Intense fear of becoming obese. This fear does not diminish as weight loss progresses.
5. No known medical illness that would account for weight loss.

6. Amenorrhea (in females).[4]

The Anorexic known as the starver is often described as a person who has a premorbid history of extreme conscientiousness, high achievement, and perfectionism, of middle and upper middle-class parents who are also, success-oriented. Such a patient does not self-induce vomiting or misuse laxatives.

The binging and vomiting anorexics, on the other hand, have more premorbid sexual involvement, tend to have more trouble with drug abuse, and tend to be more depressed than those who simply starve themselves. Stealing, somatic complaints and suicide attempts are, also, frequent in binging and vomiting Anorexics.

REVIEW OF RELATED RESEARCHES ON ANOREXIA NERVOSA

Morton (1689) diagnosed Anorexia Nervosa as a, "Nervosa atrophy from sadness and anxious cases." Gull (1873) gave the illness it's name and diagnosed it as, "A morbid mental state,'Nervosa'." He recognized the involvement of the Anorexic patient's family in this disorder and suggested isolation of the patient from the family as a necessary factor in the treatment. Lasegne (1874) recognized Anorexia Nervosa as a disorder sui generis (Anorexia hysterique). Huchard (1884) diagnosed Anorexia Nervosa as, "Anorexia Mentale," which is presently the name of the disorder in France. Janet (1903) described the obsessional and hysterical forms of Anorexia Nervosa. Dejerine and Gauchler (1913) distinguished between a secondary anorexia mentale associated with depressive or psychotic states from the primary anorexia mentale.

Between 1914 and 1934, Anorexia Nervosa was diagnosed as Simond's disease. This was due to the report made by Simmonds (1914) when he reported a destroyed pituitary gland in a woman who died of emaciation. As a result of this report, many diagnosed Anorexia Nervosa within the twenty-year period as Simmond's disease. But Ryle (1939), Richardson (1939) and Sheldon (1939) in separate researches claimed there were differences between Simmonds disease and Anorexia Nervosa. They distinguished pituitary cachexia from Anorexia Nervosa which has a psychological origin. Waller (1940) accepted the psychoanalytic formulation and rejected the pregnancy wish. Berlin (1951) accepted the oral sadistic wishes and reaction formation against incorporation wishes. Bliss and Branch (1960) claimed that any person with a 25 pound weight loss due to any kind of psychiatric condition should be diagnosed

as suffering from nervous malnutrition. Thoma (1962) described a primary Anorexia Nervosa as a discrete psychiatric syndrome clearly distinguishable Anorexia or weight loss secondary to phobic anxiety, severe depression or Schizophrenia. Bruch (1962) emphasized the distortion of body image in the Anorexia Nervosa and stressed the perceptual and conceptual disorders struggle for sense of effectiveness. King (1963) postulated a primary form of Anorexia Nervosa which he distinguished from the Anorexia of intense depression. He claimed that in the primary form of Anorexia Nervosa eating is felt to be unpleasant. Crisp (1967) claimed that a weight phobia and fear of development of the body which occurs at puberty is a feature of the primary form of Anorexia Nervosa. Russell (1969) claimed that a hypothalamic dysfunction may be the causative factor in Anorexia Nervosa. He concluded that the abnormal attitude toward food and body image may have been engendered by a disturbance of neural function. (Weight phobia is an avoidance response to pubertal development.

Researchers have identified two major groups of Anorexics: "Primary," and "Atypical".

Primary Anorexia Nervosa: Those who belong to this group become Anorexic at an early age. Most patients in this category are still in prepuberty period. The leading symptom is the relentless pursuit of thinness and denial of even advanced Cachexia as being, "too thin," are key symptoms. Those in this group, also, struggle for an independent identity.

Atypical Anorexia Nervosa: Atypical patients become Anorexic at a later age. Patients in this group will complain about their

weight loss, they do not want to stay thin, or value it only secondarily, as a means of coercing others. The leading symptom in this group is the inability to eat due to various symbolic misinterpretations of the eating function. Often, there is the desire to stay sick in order to remain in the dependent role. Atypical Anorexics are generally considered the true Anorexics in the sense that the loss of appetite in the leading complaint, though refusal to eat may occur for fear of abdominal pain or of vomiting. Characteristics of the Atypical group can be summed up as; the pursuit of thinness in the struggle for an independent identity, delusional denial of thinness, preoccupation with food, hyperactivity, strive for perfection, and, "control" not in an effort to establish a sense of identity but a way of coercing others.

The similarities between the Primary group and the Atypical group include the following; all Anorexics look alike after the condition has existed for some time. In both groups the duration of the illness is approximately the same with similar treatment difficulties namely; poor cooperation, impulsive breaking-off, and frequent changes of physicians and hospitals.

In a therapaeia roundtable in May, 1982 between Gross, Andersen, Garfinkel, Halmi, Leibowitz, and Walsh, Halmi (1982) suggested two simple tests for Anorexia patients; a complete blood count and a serum electrolyte determination. She claimed that if a low white blood cell count or a low serum potasium is found, the Primary Therapist should be very suspicious of Anorexia Nervosa.

Many researches on Anorexia Nervosa held to an earlier psychodynamic theory which claimed that Anorexic patients reject through

starvation a wish to be pregnant and have fantasies of oral impregnation. Bruch and others went further to include a dependent seductive relationship with a warm but passive father and guilt over aggression toward an ambivalently regarded mother. According to Halmi (1982), the inability to retain the mother or find a substitute in pubescence, preoedipal regressive forces push the patient back to an oral-anal mode of drive discharge and ego function.

Bruch (1962) described the disturbances of body image, disturbances in perception and a sense of inneffectiveness as being caused by false learning experiences. Russell (1969) proposed the causative hypothesis of hypothalamic dysfunction as a result of his observation that Amenorrhea and disturbance of hypothalamic thermoregulatory control are independent of emaciation in this disorder. Dickens (1970) postulated a genetic predisposition for Anorexia Nervosa and concluded that gonadal dysgenesis and Anorexia Nervosa may be expressions of some common genic aberration. Barry and Klawans (1976) proposed that a defect in negative feedback control mechanisms at central dopamine receptors accounts for the pathophysiology of Anorexia Nervosa. They concluded that increased activity of Catecholamines, especially dopamine, at some specific central receptor can account for Anorexia, weight loss, hyperactivity, Amenorrhea, decreased libido or sexual receptivity, and a morbid fear of becoming obese.

Although adequate studies have not been conducted to establish definite predisposing factors in Anorexia Nervosa, most researchers have observed that several different stressful life situations have been noted to occur shortly before the onset of Anorexia Nervosa in the patients. Observed stressful situations have included; death or

serious illness of a close relative, medical illness of the patient, failure at school or at work, the necessity to change to a new school or different job, or sexual conflicts. Anorexia Nervosa is more rampant among females from upper and middle socioeconomic class families. Stunkard (1976) claimed that Anorexia Nervosa represents an exaggeration of the strong trend toward thinness among upper-class women. While very few Anorexics are observed with the degree of sexual preoccupation, there are a few others in whom hysterical mechanisms play a role.

Garfinkel (1982) claimed that Anorexia Nervosa is multidetermined. Some factors lie within the individual, some within the family, and some are cultural. He stressed that cultural changes have influenced the idealized decrease in size of women within the past ten years. Although culture alone cannot be blamed for the spread of Anorexia Nervosa, but, it has been part of what brings the disorder out. Bruch stressed the pressure to perform for others, not oneself, in Anorexics. The role of sexuality in Anorexia Nervosa has been debatable since the girl's sexual development may be shut down because she is having Anorexia Nervosa, and not the other way around.

Another concern of researchers of this disorder is the refusal of Anorexics to have their menses. Garfinkel (1982) claimed that the problem is body fat and weight-related, but some patients lose their menses before they lose their weight. Andersen (1982) claimed that some studies have shown hormonal charges to be proportional to degree of starvation. When weight returns to normal, the body sets the point for the return to menses at eight to ten pounds higher than the point at which they initially began. Frisch claimed that a certain peripheral fat level is necessary for the start of menstrual cycles.

Another interesting area of research on Anorexia Nervosa is the area of Course and Prognosis. According to Morgan and Russell, (1975) of 400 Anorexic patients followed for a period of four years or longer show a mortality rate of five percent. Kay and Leigh (1954) and Dally and Sargant, (1960) found a mortality rate of 15 percent. Seidensticker and Tzagouruis (1968 and Theander, (1970) found a mortality rate of 17 percent while Halmi, et al., (1975) found an increase in mortality rate to have risen to 21.5 percent.

Research findings have, also, shown that many Anorexics can be described as perfectionists who lived by rigid codes of proper behavior. They tend to do everything perfectly and feel guilty if they are unable to do so. Parents of Anorexics have, also, been known to be anxious, aloof, critical, unhappy and passive. Either parents or both parents.

Reports on psychological testing in Anorexia Nervosa published have shown the following:

Smart et al. (1976) found;

1. Mean intelligent quotient in 22 female patients with Anorexia Nervosa was 109.4.
2. At 16.1 on Roven's Standard Progressive Matrices.
3. On the Eysench Personality Inventory, these patients were found to be significantly more neurotic and less extroverted than normal persons.
4. On Cattell's 16 Personality Factor Questionnaire, they were significantly more anxious, less extroverted, and more independent than normal persons.
5. On the Leyton Obsessional Inventory the symptom, trait, resistance, and interference scores were all significantly higher than those of normal persons.

Halmi (1982) claimed that the personality profile that emerged from many of the psychological tests was that of a highly neurotic and

introverted person with moderately severe obsessional features and average intelligence.[5] Theilgaard (1965)using the Rorshach on 45 patients found that the patients seemed to find it hard to create a spontaneous, emotional contact. They appeared to tolerate emotion only if it was restricted and controlled. The object relations of many of the patients seemed to be marked by narcissism and masochism. The patients had certain defense operations in common; for example, there was a general tendency to reinforce repression with reaction formation and the use of isolation, especially in the form of intellectualization. About one-third of the patients were inclined to use obsessive-compulsive mechanisms; another one-third resembled hysterical personalities and were primarily characterized by denial, repression and inhibition.

With the Thematic Apperception Tests (TAT), Theilgaard (1965) discovered an obvious feature which was the infantile-dependent attitude of the main figures toward their parents. He interpreted this TAT result outcome to mean an infantile mother fixation marked by ambivalence and feelings of guilt. In the TAT, mothers appeared twice, for as industrious, hard-working, self-sacrificing, protecting mother and also as the domineering and wicked mother.

ETIOLOGY OF ANOREXIA NERVOSA

There are four major theories of etiology:

1. The biochemical,
2. the neuroendocrinological,
3. the developmental, and
4. the familial.

Biochemical Etiological Theory of Anorexia Nervosa: This theory claims that Anorexic patients have a biochemical abnormality which produces a syndrome that may be viewed as a variant of endogenous depression. Clinical similarities have been found between Anorexia and depression, such as, problems of appetite, Amenorrhea, sleep disturbance, motor disturbance (retardation or hyperactivity), mood disturbance, anhedonia, constipation, diminished sex drive and positive family history of affective illness. Herzog (1982) in a study on the similarities between Anorexia and depression, Cantwell et al. (1977) found recurrent depression in more than one-third of the Anorexic patients diagnosed.[6]

Anorexia Nervosamay originate as a physiological or biochemical etiology through the following examples:

1. Diseases with high fever,
2. allergy,
3. lack of fresh air,
4. insufficient sleep and
5. improper diet (overfeeding, eating between meals and/or vitamin imbalance).

Neuroendocrinological Etiological theory of Anorexia Nervosa: This theory claims that hypothalamic dysfunction can lead to Anorexia Nervosa because of the pattern of Amenorrhea in Anorexic patients.

According to Herzog (1982), Amenorrhea is not simply a complication of weight loss; rather it reflects an underlying endocrinopathy involving a specific type of hypothalamic dysfunction. He claimed that in a significant number of Anorexics surveyed, Amenorrhea does occur in more than one-third of the subjects prior to weight loss and resolves only after the weight is regained. Boyer et al. claimed that there is a shift toward immature luteinizing hormone patterns which is weight dependent.[7] Also, Vigersky et al. supported Boyar's view, a finding which supports hypothalamic dysfunction in Anorexia, but does not clarify the hypothalamic role in the etiology of Anorexia Nervosa.[8]

Anorexia Nervosa may originate in a Neuroendocrinological theory through nervous excitement. Diseases affecting glandular function, e.g., the pituitary.

Developmental and Familial Etiological Theory of Anorexia Nervosa. This is often considered, also, as Psychological: This theory claims that the Anorexic is the identified person in a complicated family system in need of evaluation and psychological help. Bruch (1973) described three core developmental issues;

1. a poor definition of identity,
2. an underdeveloped sense of effectiveness and
3. a relentless pursuit of thinness as an expression of control.[9]

Munichin et al, describing the Familial theory of Anorexia Nervosa claimed there are five features common among Anorexic families; "enmeshment," "overprotection," "rigidity," "lack of conflict resolution," and, "involvement of the child in parental conflicts."[10]

Anorexia Nervosa may originate in a Developmental/Familial etiological theory in the following ways:

1. Insufficient sleep,

2. Disturbance by lack of harmony at home,

3. Refusal to eat in order to gain attention on self,

4. Extreme discipline at the table may, also, be the cause of poor appetite,

5. If mealtime becomes a period of discipline and unpleasantness, an individual may become anorexic in order to avoid the unpleasantness,

6. Some anorexics demonstrate their hostility towards parents by refusing to eat so that parents may become worried and anxious over the possibility of physical illness,

7. Parental rejection or extreme problems at school are common causes of Anorexia. Most anorexics are insecure and a home or school atmosphere characterized by criticism and punishment rather than sympathy, love and understanding, may promote more insecury and anorexia nervosa may be the outlet to get at the insecurity and be in control,

8. In most anorexic adults, a continued refusal to eat is often associated with personality structure characterized by extreme sensitivity, introversion and perfectionistic behavior,

9. Most anorexics harbor strong feelings of unresolved hostility,

10. A factor which is freuently found among anorexics is a self-punitive dynamism. In this case, the anorexic feels unworthy, guilty, and in need of punishment. Refusal to eat is an unconscious effort to punish oneself by denying basic bodily needs,

11. Since the anorexic is emotionally deprived, anorexia nervosa provides a secondary gain which serves other emotional needs. The anorexic thus finds satisfaction in the attention, sympathy and affection received by being ill. Parental pleading or pleading of those around the individual who suffers from anorexia nervosa can be powerfuls of secondary gain;

12. Family concern for slimness is high amoung the middle-class or above middle class families. To be beautiful within such families means being slim or slender. Many, who develop Anorexia Nervosa seem to reach against the belief that they are obese. They feel that they must diet stringently. Unfortunately, the diet becomes a fad and takes a serious compulsive overtone and their restriction of food intake is done painstakingly to an extreme.

CASE STUDIES OF ANOREXIA NERVOSA

CASE NO. 1

Mr. P. was medium built, handsome, well-groomed, neatly dressed in dungarees and a turtle-neck sweater. He spoke in an upper-class accent and at first I had difficulty distinguishing it. It was not English. He was aristocratic American.

"My daughter....she's 16....is in our local hospital over in Jersey. She spent Christmas there in bed. Before that it was eight months in Balies Hospital. You've heard of Columbia University College of Physicians and Surgeons in New York? Anorexia Nervosa was the diagnosis. They had her on a special floor...the tenth. The Anorexia cases are mixed in with the cancer cases. All young kids... she's only four foot, eleven inches...but she should be 90 pounds. I'm scared and my wife is scared. She won't eat anything at home, and I've been reading about the ten to fifteen percent mortality rate. She seems better in the hospital....."

The therapist, Albert M. Honig, D.O. replied... "I had worked with many people who wouldn't or couldn't eat, most of them psychotic. Inner voices commaned them not to eat. They would usually drop down to between 60 and 80 pounds and take just enough nourishment to sustain them at that weight. This might continue up to six or eight months, and then they would begin to eat and drink again and to gain weight Occasionally patients in Catatonia would give us a scare. All openings would close tight...mouth, rectum, eyelids, ears...and they would curl up in a fetal position. It was as if they believed they were back in the womb....Active efforts toward rebirth...holding, hugging, kissing, rocking and bottles which at first they ignored, but later sucked, often helped. But, I had never worked with a case that was actually diagnosed as Anorexia Nervosa."

"Please, please," shouted the father, "we know no place else to go. Let me talk to my wife. Weve got to do something."

The next day, patient 'A' arrived with her parents for admission: sunken eyes, parched lips, skin and bones, brittle hair, pitted ankles and flat buttocks, all covered with a heavy sweater and over-sized ski pants. The mother looked haggard and worried and spoke in a distinct English accent. I later discovered she was of the royal lineage.

As a child, 'A' won't eat, reported the mother. At 12 the mother decided 'A' should have some vitamins. She began to dose her daily with Vitamins C, E, A, B12, B6, and B2. She gave 'A' brewer's yeast mixed into a paste with water, two or three tablespoons at a time. With renewed confidence in nutrition and its ability to cure all ills, the mother became a devotee of Adele Davis. 'Let's Have Healthy Children', and 'Let's Get Well' became her Bibles.

At Dr. Honig's office 'A's parents hunched over in their chairs. The question of 'A's death hung over everybody. I'll do my best and we'll all work very hard, declared Dr. Honig. At the office they suddenly shifted ground, and asked eagerly, each of them if Honig could recommend an analyst for them right away.

For four days, 'A' refused to eat anything. When Dr. Honig arrived for session he was greeted with, "I want to leave, I feel hostile to the stains in the rug. This is a dirty house. My mother's house is much cleaner. I want to go home." 'A' whined in a shrill, weak voice, with no tears.

"You've got nothing on you but skin and bones. Not one piece of meat," hollered Dr. Honig back. "Who would want you? There's

nothing on you that's good to eat. Why don't you go over and pick up the vacuum cleaner and make this place comfortable. You've got no place else to go.

Obediently she vacuumed the house three times that day. She was extremely stubborn and wanted to control her own life, to eat what she wanted, when she wanted and how much. She was reaching dangerous levels of dehydration, but Dr. Honig steadfastly refused to make her starvation the focus of his thrust. She was crying to be rescured but refused all and every method devised by man to save her. She mocked the most instinctive expression of human concern for others--the sharing of bread, the giving of the apple. In 'A's mind, where the gift of physical nurturance from the parents should have been experienced as an expression of love joyously given and accepted, it had somehow come to be experienced as a sadistic form of soul control. To have accepted this control was for 'A to become a robot. In a macabre reversal of the natural order of love, to deny herself the means of life was to preserve her identity. She seemed in agony, but Dr. Honig was beginning to feel in agony too. The punishment meant for the parents was now directed toward Dr. Honig and those who worked with her.

"You are some lousy cleaner," declared Dr. Honig. "Look at that spot on this rug." Honig pointed to an ink stain. He knew nothing would remove that stain because the carpet had been to the cleaners several times, but, as he was determined to do the impossible, it seemed appropriate as a focal point. "You said you were a compulsive cleaner. Obviously you've been goofing off." Everybody looked at Dr. Honig incredulously because 'A' had done nothing else but clean. Now she was shaken and reeling. She whined and cried, but there were

still no tears. She could hardly lift the vacuum cleaner. She stumbled on one knee and began to shake with fear. "I'm gonna die here! I'm gonna die here!" It was an opening in her armor. She was beginning to feel the stress and the anxiety of fear. Her smugness dented. Everybody could feel the torment within her. She wanted to give in. She needed desperately to be held and to be loved. But, could she ask for help? Dr. Honig maintained his attitude of unconcern.

"So you'll die. You won't be the first. The whole town knows that pople die here and we secretly bury them out in the fields in back of this cottage," declared Dr. Honig. That night 'A' worked harder than ever and without letting anybody know, she made a secret telephone call to her mother and reported that she was being starved. The mother came in the moonless night at 1:00 a.m. with some food. It was now mother and daughter against the whole wicked world. She got the food to 'A' through the cracked window in her room. She hid the food away from everybody to rot and stink. It was a symbolic act of rescue and loyalty.

After two and a half months, Dr. Honig came up with what he called his vision--Hard boiled eggs. 'A' retorted that she hated eggs. Adele Davis hates eggs. Don't you know anything about cholesterol Dr. Honig?" asked 'A'. "No, you can't make me eat eggs." 'A' insisted, defending her position.

Dr. Honig reverted to his Gestapo character and ordered no more bike riding. You'll stay in the house. I won't allow you to have any fun or pleasure. Just work. Not just 18 hours a day, but 36 hours a day."

"I can't work 36 hours a day," she whined. "There's only 24 hours in a day. Everybody knows that." The next day Honig showed up in the unit and asked, "Did you eat those two eggs?" "No, I only ate one hard boiled egg yesterday and one today. My stomach won't hold two eggs. You are crazy and you are a charlatan."

"No wonder you are a midget, A. Eggs make a person strong."

'A' answered, I'm not a midget. I'm small for my age, I know, but I'm not a midget. "

Dr. Honig quickly shouted, "And you don't even masturbate. Sixteen and no periods yet." With that 'A' suddenly burst into tears and reached for the hand of a staff (Linda).

She continued her compulsions day by day, but her defiance was lessening. Her vehemence and anger were less. She seemed softer. Occasionally her face would relax when Dr. Honig wasn't around. Some days she would eat three eggs, the next day only two, then four, then four poached, five poached, defiantly substituting poached for hard-boiled. She had already gained seven pounds. She knew she wouldn't be able to eat twelve eggs, but Dr. Honig continued to insist her egg intake should be increased to twelve.

"I won't eat six," 'A' shouted.

"Yes you will! Come on, you're nearly there--six, then six more, please."

"No, you fool. You're a nut! You're a mother hate, a charlatan."

"Okay," retorted Dr. Honig. "Linda make 12 hard boiled eggs right now. I'm going to force this girl to eat one dozen eggs--force her into sanity.

"Okay," said Linda, "twelve eggs coming up," as she walked into the kitchen. There was a long silence, and then more silence. And then a deep, deep sobbing coming from 'A's direction. It came in rolls out of her. Her whole body was convulsed in a primitive grief. It seemed to be forcing its way out of her very essence. She fell on the floor, curled up in a fetal position, still heaving and crying steadily. Dr. Honig reached over and held her. She continued sobbing and clung to Dr. Honig. Tears streaked down both cheeks. "Please, please Al, (Dr. Honig's first name), I'll give in. Don't hurt me. I surrender..."

"I want someone with her around the clock," declared Dr. Honig. "One-to-one...an alter ego...someone whom she can lean on and take in, become strong with and identify with. someone to protect her. She needs this desperately at this time."

Linda placed 'A's head to her bosom and began to rock her. "I'll take care of our baby, Dr. Honig."

CASE NO. 2

The second case is also diagnosed Anorexia Nervosa, Chronic with Major Depression and also suffers from illusions and hallucinations. Age 25, father deceased. The Anorexic tendency observed after father's death. Admitted weighing 86 pounds.

In the Psychiatric Evaluation it was gathered that patient has dropped down in weight to as low as 68 pounds on several hospitalizations. Claims she is a rebellious lady and somewhat skittish about hospitals. "I don't like rules and regulations" she claimed. Has been in and out of hospitals since age 17. Father died of a ruptured stomach ulcer. Patient says father was an alcoholic. Has a brother who weighs over 570 pounds and is 5'3" tall who at the time this case study is being reported needs a stomach by-pass operation. Patient also has a twin sister who is a few minutes older.

Before hospitalization for Anorexia Nervosa, patient used to work as a nurse's aid who loves coffee so much that she drinks as much as seven cups of coffee a day.

Patient's mother is very passive. Patient also witnessed lots of fights between father and brother. Attempted suicide twice. First by swallowing mother's darvecett and second by cutting her wrist. As a child she was subject to bouts of pneumonia and dermatitis, secondary to self trauma. Suffers from extreme weekness in getting up and sitting down. Emaciated and in a dehydrated condition.

In an encounter with the patient about her refusal to eat one day in session, patient agreed to increase her weight and accepted to eat that day. In the evening she ate the recipe which she earlier gave to Phyllis, the Family Therapist. Although she ate very well that night, she was caught inducing vomiting later that evening. It was realized that evening that the patient must have inducing vomiting all the evenings she ate well since she did not gain any weight. This made it possible to diagnose the patient as also suffering from Bulemia or Bulreximia, which was not diagnosed earlier.

In a psychotherapeutic session with mother and sister it was realized that mother tends to place a lot of guilt trips on people in general, most especially her children. Patient's sister was always able to get what she wants but patient was always stubborn, hearing only what she wanted to hear. According to the sister, patient was always anhedonic, always depressed. If she won the million dollar lottery or just took a walk, it would be entirely the same. She blocks things out.

Patient's basic problem was diagnosed on first Axis as Anorexia Nervosa, chronic. Major Depression, chronic and recurrent. Passive-Agressive Personality Disorder with some anti-social traits. On t. Axis: Dysmenorrhea and Dermatitis, secondary to self-trauma with history of boils and pustules. On Axis IV: Severity of Psychosocial Stressors, Severe. Patient claims she falls apart in a crisis and has not been able to function. On Axis V: Highest Level of Adaptive function in the past year is very poor (5).

For Interventions the following approaches are being utilized:

1. The Family Model makes use of psychotherapeutic sessions with patient and sometimes with patient's mother and sister.
2. The Family Therapists and the Ancillary staff in the patient's unit provide the support system through nurturing. Love and warmth is constantly provided to the anorexic patient.
3. Patient is allowed to take part in the cooking and help make some of her favorite foods.
4. Once when patient suffered from emaciation she was sent to the nearest hospital.
5. The patient, in order to regain her superego, is attached with a day-nurse and a night-nurse. This is to allow patient to be on a one-to-one attachment with the nurses.
6. As part of the patient's treatment plan she is expected to put down in writing some of her thoughts and her dreams.

POSSIBLE TREATMENTS OF ANOREXIA NERVOSA

The most consistent indicator of good outcome in the treatment is early age onset of anorexia nervosa. The most consistent indicator of poor outcome is late age onset of the illness (Frzier, 1965; Rowland, 1970; Halmi et al., 1973, 1975). Such factors as childhood neuroticism, parental conflict, bulimia, vomiting, laxative abuse and various behavioral manifestations such as obsessive compulsive, hysterical, depressive, psychosomatic, neurotic and denying symptoms have been related to poor outcome in some studies and have not been significant in affecting outcome in other studies.

The treatment of Anorexia Nervosa is more than inducing weight gain. This is not an illness of weight and appetite alone. The essential problem relates to inner doubts and lack of confidence.

All those who have treated Anorexia Nervosa have agreed to the fact that the weight problem must first be tackled before the patient can be in any position to undergo therapy. A decision on treatment depends on many individual circumstances such as the age of the patient, the severity of the weight loss and general condition, the duration of the illness, the emotional climate of the treatment center and the quality, experience, and treatment philosophy of the available treatment center or hospital.

In chronic conditions, heroic measures of correcting the electrolyte balance through intravenous infusion are often necessary. The need for the intravenous infusion is due to the fact that the acute danger to life may not come only from severe emaciation, but, also from the serious disturbances in the electrolyte balance, particularly in patients

who use vomiting, laxatives, and diuretics to keep their weight at the lowest level.

As soon as the weight level is above the frightening level, therapy should start to focus on normal psychological functioning and the exploration of important and relevant problems. The program for the normal psychological functioning and the weight gain should be carefully handled by a therapist who has a good control over the nurses and the dieticians working with the patient. The Anorexic patients are good manipulators and they are very good at playing nurses or doctors or therapists against themselves. Those who work with the Anorexic should be cautious and disallow the patients from manipulating them against themselves.

The first step in the treatment of Anorexia Nervosa is the medical examination. Such an examination will rule out any possible physical conditions which might be responsible for the disorder. This medical examination is necessary irrespective of what treatment approach is contemplated for the patient.

During medical examination the physician should examine the patient's physical state, e.g., vital signs, hematocrit, serum calcium levels, and blood urea nitrogen, in order to determine whether it was necessary to hospitalize the patient.

DRUG THERAPY TREATMENT OF ANOREXIA NERVOSA

The most commonly used drugs in the treatment of Anorexia Nervosa are the antipsychotics and the tricyclic antidepressants. Chlorpromazine is the most widely presented antipsychotic in the treatment of Anorexia Nervosa. Although the relationship between chlorpromazine and weight gain remains unclear, it has been proposed that Chlorpromazine induces weight gain in Anorexics via fluid retention, hypothalamic effects, and increased lethargy. Dally et al (1979) reported that one year after admission, the physical or emotional status of anorexic patients who were given Chlorpromazine was not different from the status of anorexics who had not received the drug.

The antidepressants most widely prescribed is the tricyclic antidepressants. Case reports of amitriptyline and Imipramine use in certain patients have yielded good results with improvement in weight, eating heabits and mood. Needleman (1976, Moore (1977) and White (1979). The side effects of Amitriptyline reported include anticholinergic effects, sedation, dry mouth, tachycardia and postural hypotension. Although these reactions are usually transcient and mild, patients should be made aware of them and dosages can be reduced until adverse reactions stop. In a double-blind study on the effect of Chlomipramine on Anorexic patients it was realized that Chlomipramine was associated with increased appetite and more appropriate eating habits, but it was not associated with weight gain, Lacey (1980).

Another drug which has been successfully used for the treatment of Anorexia Nervosa is the Metaclopramide. The use of this drug has made it possible for Anorexic patients to have delayed gastric emptying of a standard meal. It has also improved weight and gastrointestinal symptoms. Saleh (1980).

Cyproheptadine, a drug known as a serotonin antagonist was found to be effective in a controlled study of anorexic patients to be effective as an appetite stimulant. This drug was found useful for the more severely ill patients with history of birth-delivery complications and prior outpatient treatment failure. Goldberg (1979). Johansson and Knoor, in their own research tried Levodopa on six anorexic patients, four of which gained weight. But the side effects of the drug included scalp hair loss and blackening of the urine.

Other drugs used to treat Anorexia Nervosa Include:

A. Glycerol - Used in an experiment by Caplin et al (1973).

B. Phenoxybenzamine (Dibenzyline) experiment by Redmond (1976).

C. Pimozide - An investigational selective dopamine - blocking agent - experiment by Plantey (1977).

D. Lithium Carbonate has been reported to induce weight gain. The basis of this is that the clinical manifestations of Anorexia, i.e., diminished sleep, increased motor activity, and unstable mood, resemble mania. But the risk in the use of Lithium is the high Lithium toxicity in Anorexics and their inadequate intake of salt.

Although most of the drugs mentioned may have positive effects on Anorexics, the fear expressed in the use of drugs are; the side effects of some of the drugs, the inability to control relapses after the use of medication stops, and the inability to measure whether other factors apart from the drugs are responsible for the management of Anorexia Nervosa.

PSYCHOTHERAPEUTIC TREATMENT OF ANOREXIA NERVOSA

Therapy for the Anorexic patient is directed to the parents, family environment, as well as, to the patient. Family members are made to realize that the patient's difficulty is primarily a reaction to family surroundings and that, if the Anorexic is to overcome the problem, the environment as well as the Anorexic's attitude must improve. Psychotherapy tries to uncover the basic underlying personality dynamic problems, which must be resolved. In many cases Anorexics tend to possess an inadequate self-concept and are unconsciously attempting to punish themselves by this disorder. In therapy, the dynamics of this punishment must be explored in detail such as the feelings of insecurity and inadequacy.

Of all the other treatments of Anorexia Nervosa, psychotherapy is the accepted treatment plan at the Delaware Valley Mental Health Foundation, Doylestown, Pennsylvania. With the family model approach, the treatment provides for emotional support and structure for the Anorexic patients. The family model avoids rigid behavior contracts and disallow the power struggle with the Anorexic patients. In individual or group therapy the Primary Therapist helps patients on their marked degree of interpersonal distrust and helps them understand their problems. The physiology of starvation, patient's maturational fears and the patient's fears of losing control are all tackled in individual, group, or family sessions. Also, at the Foundation, personal nurses who work day and night shifts are provided to work with the Anorexic patients. A dietician is, also, provided to work with the Anorexic patients. Other activities which support therapy at the Foundation include; dance therapy, art therapy, psychodrama, and Survival Skills in which the patients are encouraged to learn survival.

The Primary Therapist urges the family therapist, the ancillary staff and other staff members who have contact with the Anorexic patients at the Foundation to provide the patient with some kind of assertive behavior or training because so many Anorexic patients are people pleasers and the only way they've been able to assert themselves is through the disorder. In learning to stand up for themselves in other areas the Anorexic can more easily give up their refusal to eat, because they can now assert themselves in other ways. The family model support system provides the Anorexic with a sense of autonomy and a help to feel more effective.

HYPNOSIS AND BIOFEEDBACK IN THE TREATMENT OF ANOREXIA NERVOSA

Hypnosis and biofeedback which are helpful in teaching relaxation are often used in treating Anorexia Nervosa. Many of the Anorexic patients are overactive, they often keep themselves busy in order to forget their hunger. Self hypnosis is encouraged to teach Anorexics to relax and become more in touch with their bodies, instead of blocking their feelings.

BEHAVIOR MODIFICATION TREATMENT OF ANOREXIA NERVOSA

Most behavior therapy programs follow an operant condition paradigm, with positive reinforcements consisting of increased physical activity, visiting privileges and social activities contingent on weight gain. Some behavior modification treatment research programs have included strong negative reinforcements, such as bed rest, isolation, and tube feeding. Reinforcements contingent on weight gain, rather than on eating behavior are more frequently used. (Bachrach et al., 1965; Blinder et al., 1970; Brady and Rieger, 1972; Garginkel et al., 1973; Halmi et al., 1975). Although some of the studies have claimed that behavior modification helps weight gain faster than other treatment approaches (Wulheimier et al., 1978). The relapse of Anorexic patients who underwent behavior modification treatment are reported higher than other treatment approaches.

Anorexia Nervosa is yet an unexplained syndrome with psychologic neuroendocrinological, and physical components for which there is yet to emerge a specific treatment. The listed management techniques listed in this paper are individualized which include medical, psychotherapy, hypnotherapy and behavior modification. Psychotherapy is highly recommended among all the other treatment approaches since it is

considered the most effective with little or no relapses. Drugs can be used as an adjunct to psychotherapy if need be. The mortality rate of Anorexics is very high among patients who receive short-term treatments such as behavior modification and drugs. Prolonged psychotherapy is, therefore, suggested to gradually take care of all the Anorexic basic inner conflicts.

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